Compendium of Health Policy Options

A Presentation to the Maryland Health Care Commission

February 15, 2007

Stephen J. Salamon
Chairman

Rex Cowdry, M.D.
Executive Director

MHCC MARYLAND HEALTH CARE COMMISSION

Outline

- Overview of the issues
  - Cost, quality, access and the uninsured, information
- Quality, Outcomes, and Value Initiatives
- Initiatives to promote higher value in health care expenditures
- Health Information Technology Initiatives
- Specific Small Group Market Options
  - NAIC 1993 rating standards
  - Strategies to address risk selection from ERISA plans or uninsured
  - Expansion to 75 or 100 employee groups
  - High Performance Plan Design
- Making Insurance More Affordable for the Purchaser
  - Reinsurance
  - Dependent Coverage Changes
- Broader health reform principles and options
  - Massachusetts reforms
  - California's recent reform proposal
  - Senator Pipkin's proposal (CHOICE)
  - Staff analysis: an exchange in Maryland

Fundamental Issues

- Access to health insurance and health care
  - In 2005, approximately 780,000 Marylanders, including 140,000 children were uninsured
    - 14.2% of the total population – 15.8% of the under-65 population
  - Key facts about the uninsured:
    - The majority are young and healthy
    - Small businesses have a disproportionate share of uninsured workers
    - 83% live in families with at least one adult worker
    - 44% are single adults with no children
    - 47% have family incomes below 200% FPL (approx. $40,000 for a family of 4)
      - 35% have family incomes above 300% FPL (approx. $60,000 for a family of 4)
    - 27% are not US citizens
    - 39% of Maryland's Hispanic population and 19% of its African-American population are uninsured
  - Being uninsured reduces access to health care and contributes to poor health
  - Care is often provided in the most expensive setting with the least continuity of care – the Emergency Department
  - We all pay the cost of caring for Marylanders who either cannot afford or choose not to get health insurance

- The Costs of the Uninsured in Maryland *
  - **Direct costs – estimated at $1.8 billion**
    - Maryland State government
      - increased hospital rates — $ 34 million
      - state public and mental health programs — $439 million
    - Federal government
      - increased hospital rates — $239 million
      - share of public/mental health programs and FQHCs — $195 million
    - Local governments — $ 14 million
    - Health plans – increased hospital rates — $165 million
    - Private physicians – uncompensated care — $295 million
    - Out of pocket payments by the uninsured — $445 million
  - **Indirect costs - estimated at $1.4-$2.9 billion**
    - poorer health, less productivity

- Premiums for family coverage were estimated to be $948 higher because of uncompensated care in 2005

* Source: "Maryland HRSA State Planning Grant: The Costs of Not Having Health Insurance in the State of Maryland" – 2002 estimates projected to 2007

Fundamental Issues

- Health care costs are much higher than in other developed countries and continue to rise more rapidly than income or GDP
  - Technology is a key driver. New drugs, diagnostic tools, procedures are introduced early and used extensively
  - Lack of information about effectiveness, best practices, relative value
  - Misaligned incentives of third-party payments provide little reason for patients and providers to pay attention to cost and value
  - Spectre of liability leads to defensive medicine
- Health care quality is quite variable
  - Wide variations in practice patterns, adherence to guidelines
  - Unacceptably high rate of medical errors
  - Care of chronic illness is poorly coordinated
  - Management tools (information systems and incentives) are weak
  - Current incentives do little to encourage quality care

Fundamental Issues (cont.)

- Health care markets are flawed
  - Incentives are misaligned
    - Payment for services rather than payment for outcomes
    - Third party payments mean neither doctor nor patient has a major financial stake in choosing the highest value health care
      - Managed care was an agreement between purchasers and health plans
      - The challenge is bringing doctors and patients into the cost-control process
  - Market is increasingly concentrated, limiting effective competition
    - Most evident in the small group market, where 2 companies have a 92% market share – both oligopoly and oligopsony issues
    - Increasingly a problem in the hospital market – although effects are less striking in Maryland because of the all-payer system
  - Consumers lack good information
    - To compare the costs, quality, and benefits of health plans
    - To compare the costs and quality of providers
    - To evaluate alternative treatments for effectiveness and value

Quality, Outcomes, and Value Initiatives

- Creation of Maryland Patient Safety Center
- Expanded health plan evaluations
  - Collaboration with Mid-Atlantic and National Business Groups on Health to broaden performance measures
- Expanded hospital quality measures
  - Infections
  - Cardiac care
- Expanded nursing home quality measures
  - Administration of influenza vaccination during the flu season
  - Administration of pneumococcal vaccine
  - Experience of care surveys
- Develop quality measures for assisted living, home care, community-based service
  - Collaborative with AHRQ/CMS
- Price transparency
  - Payments to hospitals for common DRGs
    - Includes both health plan payments and patient out of pocket
  - Payments to providers for ambulatory care services
    - By specialty and region
    - Includes both health plan payments and patient out of pocket

Strategies to Address Rising Health Care Costs

- **Consumer incentives** to choose healthy life style and high value health care
  - Premium reduction for non-smokers, normal weight
  - Health Savings Accounts (HSAs), Healthcare Reimbursement Arrangements (HRAs), and Health Opportunity Accounts (HOAs)
  - Tiered coinsurance based on evidence of effectiveness and cost-effectiveness
  - Incentives for participation in disease management programs, when indicated
  - High performance networks, centers of excellence
- **Provider incentives** to deliver high value, high quality care
  - Pay for value / pay for performance
  - High performance networks
  - Pay for use of health IT, especially decision support software
  - Medical liability protection for guideline-concordant care, other medical liability reforms
  - Confidential or public reporting of detailed performance measures
- Benefit redesign to emphasize high value, evidenced based medicine

Health Information Technology Initiatives

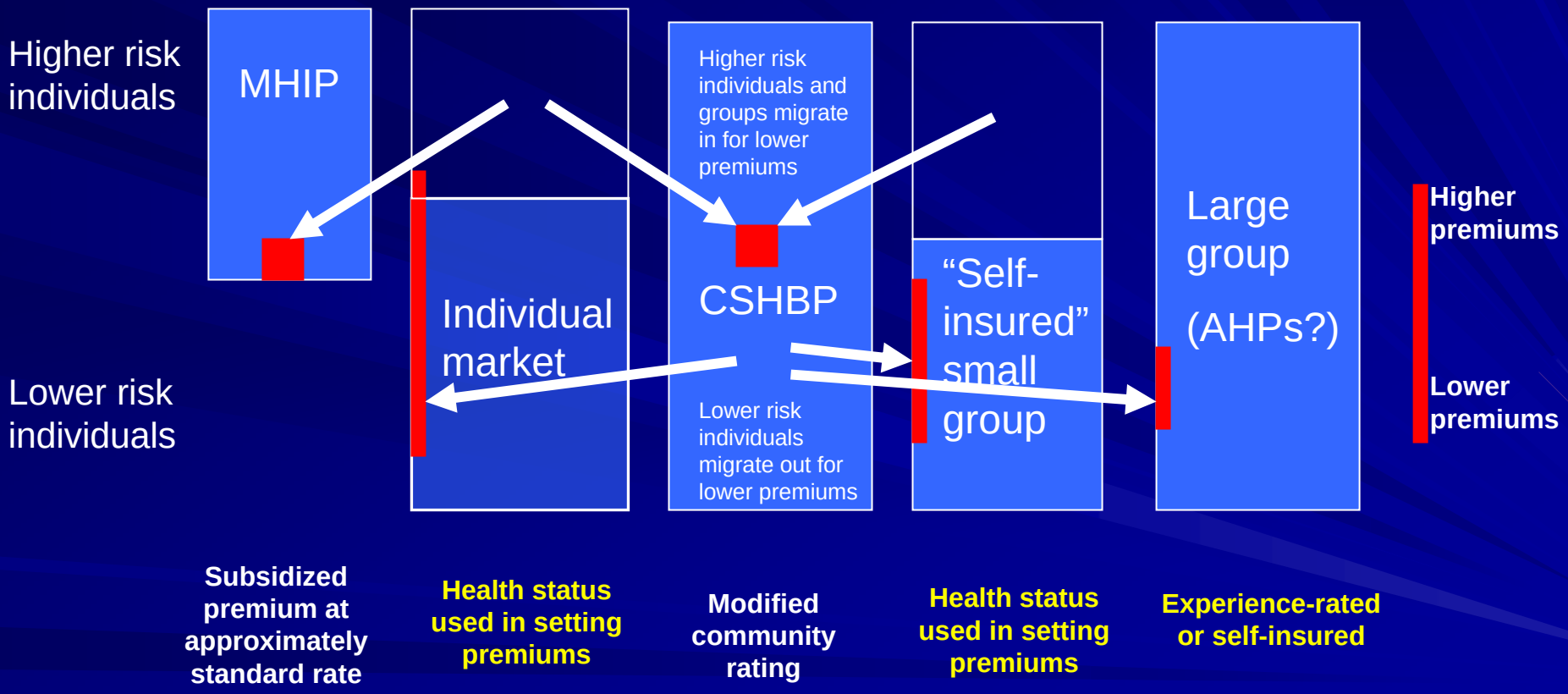
- Deliver the right information about the patient, treatment options, and coverage to the point of care to:
  - Improve quality
  - Prevent medical errors
  - Promote value
- Gathering the right information to:
  - Determine what works
  - Identify adverse effects
  - Conduct biosurveillance
- Two key components:
  - Electronic health records with decision support
  - Private and secure information exchange
- State efforts
  - Task Force on the Electronic Health Record
  - Privacy and Security Study
  - Competitive planning projects for health information exchange with HSCRC (2007)
  - Implementation project for health information exchange with HSCRC (2008)

Health, Risk, and the Marketplace

- Risk pools - fundamental but full of complex issues
  - Types of pools
    - Employment
    - Association membership
    - Geography (state-wide pool)
    - Group / individual markets
    - Low income
    - High risk pools
  - Maintaining the integrity of the pool – avoiding death spiral
    - Representative array of risks
    - Protect boundaries – avoid adverse selection
  - Rating principles
    - Community, blended, or full risk rating
    - Are the rules for new entrants the same as established members
  - Benefit design
    - Role of state mandates or minimum benefit rules for the pool
  - Choice of plans within the pool
    - Highly desirable option for individuals
    - Adverse selection among plans must be addressed

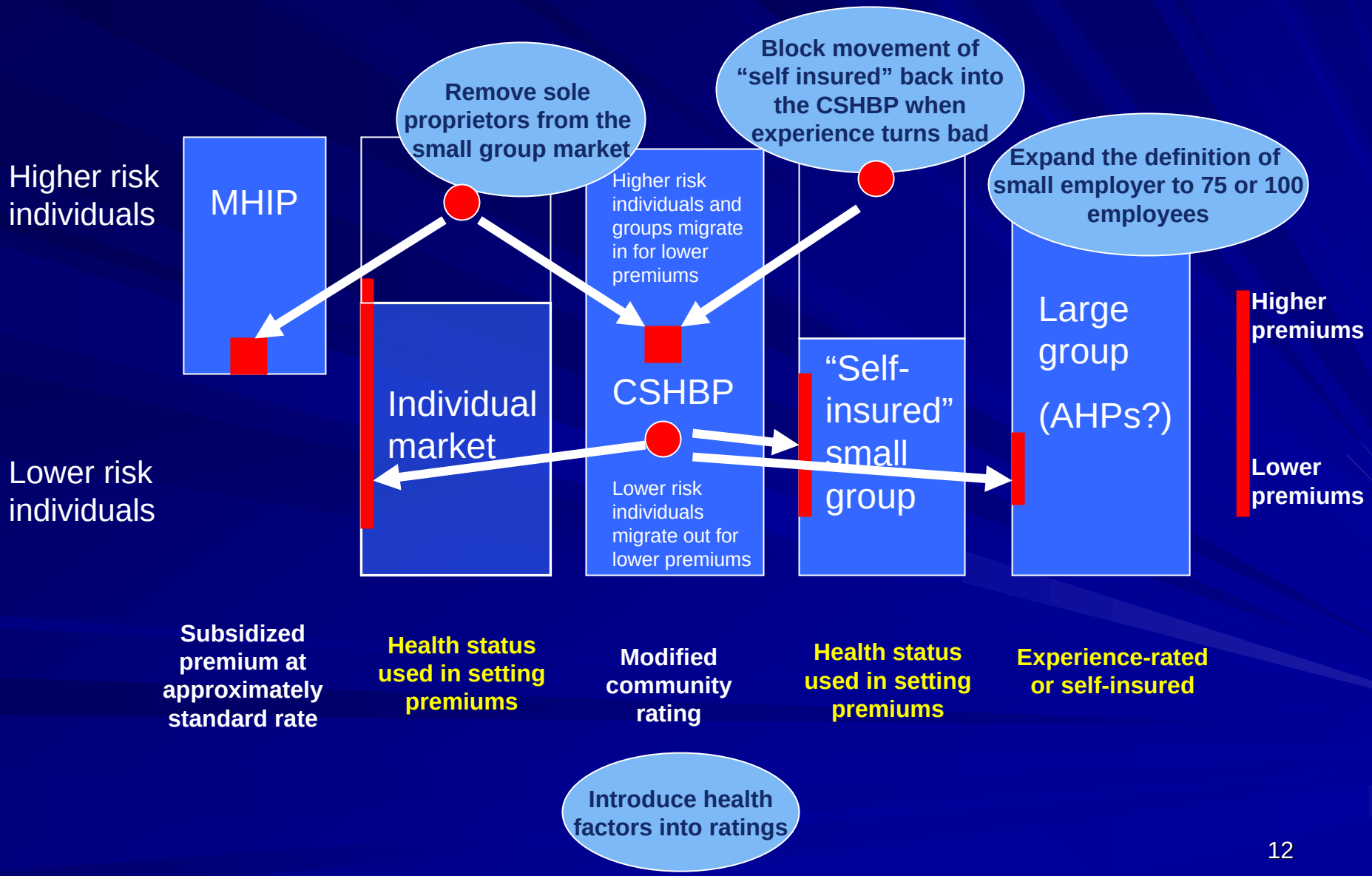
Health, Risk, and the Marketplace

Risk selection harms the pool when rating principles differ



Health, Risk, and the Marketplace

Risk selection harms the pool when rating principles differ



Specific Small Group Market Options

- NAIC 1993 rating standards
- Core benefit design
- Expansion to 75 or 100 employee groups
- High Performance Networks
- Subsidized reinsurance for the SGM

NAIC 1993 Rating Standards

- Rating in SGM currently includes age of the group, family status and geography.
- NAIC 1993 standard adds health status, gender, industry, and firm size to rating structure
  - 32% would see premiums increase by 10% or more
  - 42% would see premiums drop by over 10% (reduction reflects older and sicker people without coverage – not improvements in efficiency)
- Impact on Coverage in Maryland
  - Older and sicker people in small firms that would drop coverage due to increased premiums while younger and healthier people would become covered in small firms that start to offer coverage due to a reduction in premiums for a net reduction in ESI coverage of 22,770
  - The number of uninsured in Maryland would increase by 22,200 people, resulting in an increase in uncompensated care as well as an increase in Medicaid enrollment and spending

Expansion of Small Group Market

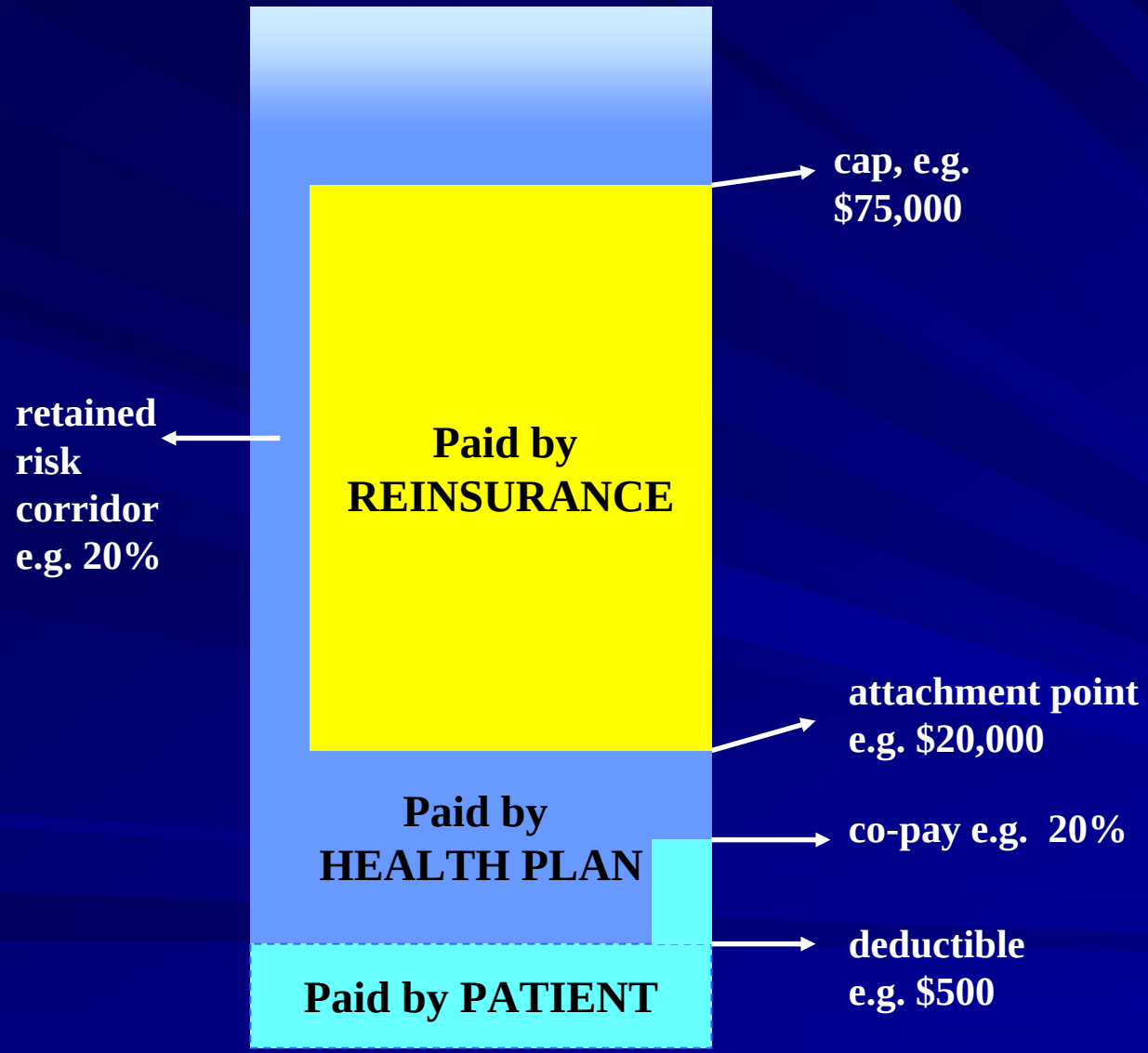
- Mercer was contracted to examine the feasibility of broadening the definition of small group to 75 or 100 employee groups
- Larger groups will have an incentive to exit the market and self insure
- Adverse selection is likely
- Unlikely to result in new carriers entering the market
- Estimated to increase premiums at a minimum of 2% to 5%

High Performance Plan Design
(MHCC and Mercer analyses)

- High performance plans ideally have at least three key components:
  - Network providers are selected based on their ability to produce quality outcomes at lower prices per episode of care or per year
  - Covered services and cost sharing arrangements emphasize high value, evidence-based care
  - Individuals with substantial health care costs are enrolled in disease management or case management programs
- While high performance plan designs have been discussed for quite some time, their introduction into the market is relatively recent and focused primarily on identifying high performance provider networks on the basis of cost savings
  - Marketed mainly to the large group employer market
  - Savings from high performance networks range from 5% to7% based on anecdotal reports
  - Savings from disease management and wellness programs in the range of 1% to 2% are certainly achievable
  - There may be an additional 2% to 5% available depending on the structure of the network and the position taken with regard to certain mandates

Making Insurance More Affordable for the Purchaser

The Concept of Reinsurance



Reinsurance can be used to:

- Reduce premiums through government subsidy
- Compensate for adverse risk selection among plans

Healthy New York (HNY)

- Established in 2001, HNY is a publicly-funded reinsurance program for private coverage that assumes a portion of insurer's high-cost claims.
- State subsidizes costs for expensive people with the goal of lowering premiums for all.
- Reinsurance fund assumes 90% of the costs incurred between $5,000 and $75,000
- Enrollment available for:
  - Small firms with low-wage workers that did not provide coverage in the past 12 months
  - Low income self-employed
  - Uninsured workers without access to employer sponsored insurance
- Over 110,000 net enrollees at year end, 2005.
- Most (74%) of the enrollment in HNY is among individuals amd sole proprietors, with employees of small businesses accounting for only 26%.

Changing Definition of Dependent

- In 2006, 25 states introduced legislation that would change the definition of dependent
- The upper age limit is generally between 24 and 26.
- Legislation often includes other requirements such as:
  - Coverage must be continuous
  - After leaving the policy, the child cannot opt back into parents' coverage
  - Child cannot be eligible for ESI
  - Child must be unmarried and not have any dependents
- Legislation may allow specific additional premiums
- NJ's new law effective since May, covers uninsured, unmarried adults under age 30 who have no dependents and are either state residents or full-time students.
  - It does not require employers to contribute to coverage for young adults, and it does not apply to large companies' self-insured plans or plans issued and delivered outside of the state, even if they cover New Jersey residents.
  - The cost of the extended coverage is capped at 102 percent of the premium previously paid for that dependent's coverage prior to them aging out.
  - Expects about 200,000 young adults to receive coverage under the new law.

Health Care Reform Challenges

Health Care Reform Challenges: What Are the Key Questions?

- Is near universal coverage a key goal?
- Do individuals have a choice of plans?
  - If so, do they have better ways to comparison shop?
  - If so, are there ways to address adverse selection?
- What is the responsibility of the individual?
  - Maintain insurance – but only at higher incomes?
  - Maintain insurance at all incomes, if individual's costs are "affordable"
- What are the responsibilities of the employer?
  - Play or pay?
  - Choose coverage or provide defined contribution?
  - The challenge of ERISA
- What are the responsibilities of government?
  - Deliver health care?
  - Fund the delivery of health care to all?
  - Support those most in need
- Does the proposal have any meaningful ways to control costs and improve value?

Assuring a Viable Risk Pool

- What is an ideal pool?
  - Large and broadly representative of the population
  - High participation by eligible pool members
    - Especially, high participation by healthy members
  - Exclusive source of insurance for eligible pool members
    - No competing options outside the pool that are more attractive to the healthy
    - If there is competition, the rating principles (what factors determine the premium) are the same
  - Restrictions on entry
    - Prevent preferential entry by people who need insurance because they are ill
- Pools with problems
  - Small businesses themselves (small size, highly variable age/risk profiles)
  - Medicare (age and/or disability)
  - Some long-established large employer and government pools (aging)
  - Most purchasing pools for small businesses
    - Increased purchasing power and economies of scale? Generally not.
    - Some compete directly with direct sales by the health plan
    - Healthy small groups can turn to individual market
    - Larger small groups sometimes consider self-insurance with stop-loss

Reform Challenges (cont.)

Targeting Subsidies Effectively

- Limit the subsidy to the currently uninsured
  - Direct toward:
    - Employers not currently offering
    - Employees offered but not taking up offer
  - Substantially improves "efficiency" – the bang for the subsidy buck
  - Paradox of "immediate ineligibility"
  - Hard to meet the "fairness" test
  - There is an incentive for employers and employees to find ways around the restrictions
- Subsidize specific markets
  - Individual market
    - High risk pools (MHIP)
    - Reinsurance (Healthy New York)
  - Small businesses
    - Challenge: take up not very sensitive to price (high retention, little entry)
    - General subsidy to businesses and employees would go largely to currently insured
    - Could target subsidy either to currently uninsured or to low income employees – or to currently uninsured low income individuals
  - Large businesses
    - High offer and take-up rates
    - Low-income subsidy in conjunction with other markets – but "crowd-out" is a problem

Targeting Subsidies Effectively

- Subsidize the employer rather than the employee
  - Subsidies may not get passed through to employee
  - Subsidize only certain employers
    - Very small businesses
    - Businesses with high proportion of low wage workers
  - Drawback: Harder to target funding to individuals most in need
- Subsidize only low income individuals and families
  - Mechanisms:
    - vouchers
    - tax credits
    - exchange
  - Options for using subsidy:
    - Special program with special benefit design
    - Defined contribution with family choice

Crafting an Affordable Plan

- Defining core benefits
  - Affordability requires restraint in breadth of benefits
    - Concept of core benefits
    - Must withstand strong political pressures to mandate services and providers
    - Benefits ideally reflect evidence-based medicine and high value
  - Affordability may be enhanced by high performance networks
  - "Affordable cost sharing" helps control utilization
    - But preventive and disease management services should have little or no cost sharing
- Defining affordability
  - Affordability without a subsidy (e.g., at 300% FPL)
  - Affordability of subsidized plan at lower income levels
    - Usually a progressively lower percentage of income as income decreases

The Starting Point for State Reforms: If you've seen one state...

Non-elderly in 2004	MD	MA	CA	U.S.
Percent Uninsured	16.3%	13.1%	20.7%	17.8%
Percent with ESI	69.2%	69.4	55.6%	63.2%
Percent on Medicaid	8.1%	14.5%	16.8%	13.3%
Medicaid Eligibility Levels				
Parents	***39%***	***133%***	***107%***	
Pregnant Women	***250%***	***200%***	***200%***	
Children (<19)	***200%***	***150%***	***(1-5) 133%***	
			(5-19) 100%	
SCHIP (children <19)	***300%***	***200%****	***250%***	
Percent Under 250% FPL	29.5%	28.7%	42.8%	38.8%
Percent Under 250% Who Are Uninsured	32.5%	22.4%	31.6%	29.3%
Percent Who Are Uninsured & Under 250% FPL	9.6%	6.4%	13.5%	11.4%

Source: U.S Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2005.

* Massachusetts' recently enacted health care reforms expand MassHealth eligibility for children from 200% to 300% FPL

Workforce & Economic Characteristics

	MD	MA	CA	U.S.
Percent of Private Sector Firms < 50 Employees (2004)	26.9%	27.4%	29.8%	29.1%
Avg. Employee-only Premium in Private Sector Firms < 50 Employees (2004)	$3,838	$4,509	$3,372	$3,764
Percent of Workers in Firms with Majority of Low Wage Workers (< $10/hr.) (2004)	22.3%	19.1%	26.1%	30.0%
Per Capita Income (2005)	$31,109	$31,007	$26,800	$25,035
Unemployment Rate (2005)	4.1	4.8	5.4	5.1

Sources: Tabulations based on data from 2004 MEPS Survey, U.S. Agency for Healthcare Research and Quality; Data Profile Highlights - 2005 American Community Survey, U.S. Census Bureau; and Bureau of Labor Statistics, U.S. Department of Labor, www.bls.gov/lau/lastrk05.htm

Massachusetts' Health Care Reform Bill

- Impetus – Threat of losing $385 million in federal funds
- Signed into law by Gov. Romney in April 2006
- Aims to Cover 95% of Uninsured within 3 years through the following components:

  - **Individual Responsibility**
    - All residents must obtain coverage
    - Penalties assessed if "affordable" coverage is available

  - **Employer Responsibility**
    - "Fair Share" employer contribution – Employers with 11+ workers who don't offer coverage must pay $295 per worker
    - Employers must facilitate Section 125 "cafeteria plan" for pre-tax health insurance
    - "Free Rider Surcharge" – Non-offering employers (11+ workers) with frequent Uncompensated Care Pool users may be charged up to 100% of costs over $50K

MA Health Care Reform (cont.)

- **Insurance Market Reforms**
  - Creates Commonwealth Health Insurance Connector (Administered by quasi-public authority)
    - Makes private plans available on pre-tax basis
    - Reduces administrative burden for small businesses
    - Allows portability when changing jobs
    - Allows part-time workers to combine employer contributions
  - Merge non-group (individual) market with small group market
  - Modified community rating –
    - Rating factors: age, industry, geographic area, wellness program usage, tobacco usage, or rate basis type
  - Extends definition of dependent coverage
- **MassHealth/Medicaid Expansion**
  - Children's coverage expands to 300% FPL ($60,000/family of 4) from 200% FPL
- **State-sponsored Incentives**
  - Commonwealth Care Health Insurance Program
    - Subsidized coverage for lower income uninsured below 300% FPL (no deductibles; no premium if below poverty; sliding scale between 100-300% FPL)

Comprehensive Reform Proposal: California

- Gov. Schwarzenegger recently unveiled a comprehensive health reform plan to address the state's 6.5 million uninsured residents.
- Major components include:
  - Individual mandate
  - Expansion of coverage
    - All uninsured children below 300% FPL, regardless of immigration status eligible for state-subsidized coverage
    - Expands Medi-Cal coverage for adults up to 100% FPL, who are legal residents
  - Premium assistance for low income residents
    - Uninsured adults with incomes between 100-250% FPL will receive premium assistance to assist in purchase of coverage through a newly established purchasing pool
  - Increase provider reimbursement
  - Improve insurer efficiency through an increase in medical-loss ratio to 85%
  - Requires employers to establish Sec. 125 plans
  - Implements health and wellness incentives

California (cont.)

- Additional reforms include initiatives to cut regulatory barriers, expand health information technology, reduce medical errors and use their purchasing power through Medi-Cal to enhance care, quality and efficiency.
- Similar to Massachusetts' plan – this proposal builds on the concept of 'shared responsibility – shared benefit'
  - Increased Medi-Cal rates and eliminating the uninsured is expected to direct $10-$15 billion in new money to hospitals and doctors.
  - Assessments of 2% on doctors and 4% on hospitals will be used to help cover the increased Medi-Cal rates.
  - Employers if 10 or more, who do not provide coverage will pay an "in-lieu fee" of 4% of payroll.

Senator Pipkin's "CHOICE" Plan

- **Insurance Market Reforms**
  - Creates Maryland Health Insurance Exchange (Governed by MHCC)
  - Merges individual and small group markets
  - Eliminates MHIP over 3 years
  - Gives large employers the option to participate
  - Mandates that Maryland state employees participate
  - Provides guaranteed issue, renewal and portability among plans
  - Eliminates mandates
- **Rating Principles**
  - Modified community rating, adjusted for age (not to exceed +/-55% of the community rate) and geography (up to 20%)

Senator Pipkin's "CHOICE" Plan (cont.)

- **Enrollment/Claims Processing**
  - Brokers are entry point into Exchange
  - Broker commissions of not less than 5% of premium
  - MHCC can contract with TPAs
- **Reinsurance/Risk Transfer**
  - Creates a Health Insurance Risk Transfer Pool
- **State Sponsored Incentives**
  - Tax credits against state income tax, not to exceed the tax amount

Modeling a Comprehensive Option for Maryland

- Radical Goal to be modeled: Near-universal coverage (>98%) through
  - incentives (premium subsidies)
  - penalties (for uninsurance)
- Principles:
  - Personal responsibility
    - must have at least catastrophic coverage - no free riders
  - Individual choice
    - Each employee can choose coverage
  - Public responsibility
    - Premium support for low income Marylanders
  - Employer responsibility
    - Offer employees access to exchange
    - Provide payroll deduction and a Section 125 premium conversion plan
    - Employer chooses a defined contribution – but is not required to contribute
- Merge individual and small group markets, including MHIP
  - Guaranteed issue and renewal, modified community rating
  - Exchange is the only way to obtain fully insured coverage
- Assure broad participation through:
  - Serious penalties for remaining uninsured (75% of HDHP)
  - Generous affordability standard - sliding scale
    - Contribution to premium is $0 at incomes below 100% FPL
    - Contribution to premium is 7.5% of income at incomes from 250 to 300% FPL
- Benefit design equivalent to BC/BS Basic plan

Modeling a Comprehensive Option for Maryland

- A public-private exchange can:
  - Give individuals and employees a choice among health plans
  - Structure the market, providing:
    - Better competition among health plans
    - Better comparative information to guide individual choice
    - Greater flexibility and innovation in plan designs
  - Provide portability between jobs, promoting continuity of care
  - Make it possible to combine health benefits from several part time (or full time) jobs
  - Make it simpler for employers to provide health insurance
    - Administrative burdens significantly reduced
    - Provides a way for employers who don't currently offer health benefits to contribute toward health insurance costs
  - Efficiently combine individual and employer contributions with:
    - A premium support program for low-income Marylanders
    - Any available Federal tax credits for low-income individuals
  - Manage risk selection among plans by:
    - Assessing whether there is risk selection,
    - Adjusting premiums paid to plans based on the risks they enroll,
    - Administering a plan of reinsurance, or
    - Assuring that high cost individuals receive effective disease or case management

Modeling a Comprehensive Option (cont.)

- Personal Responsibility
  - Create a state-wide program to spread risk and offer choice in the same way a large employer's health plan spreads risk and offers choice
  - Broad participation by all eligible Marylanders is essential to success of the risk pool
  - Individuals who do not purchase insurance increase both the taxes and the cost of health insurance for everyone else
  - Health insurance coverage, like automobile insurance, should be expected of everyone
  - Enhancing personal responsibility requires:
    - Affordable insurance plans
    - Premium support for low income individuals
    - Incentives and penalties to assure that everyone is "in the pool" and contributing premiums
      - Modeling estimated include a tax penalty equal to 75% of cost of a HPHP

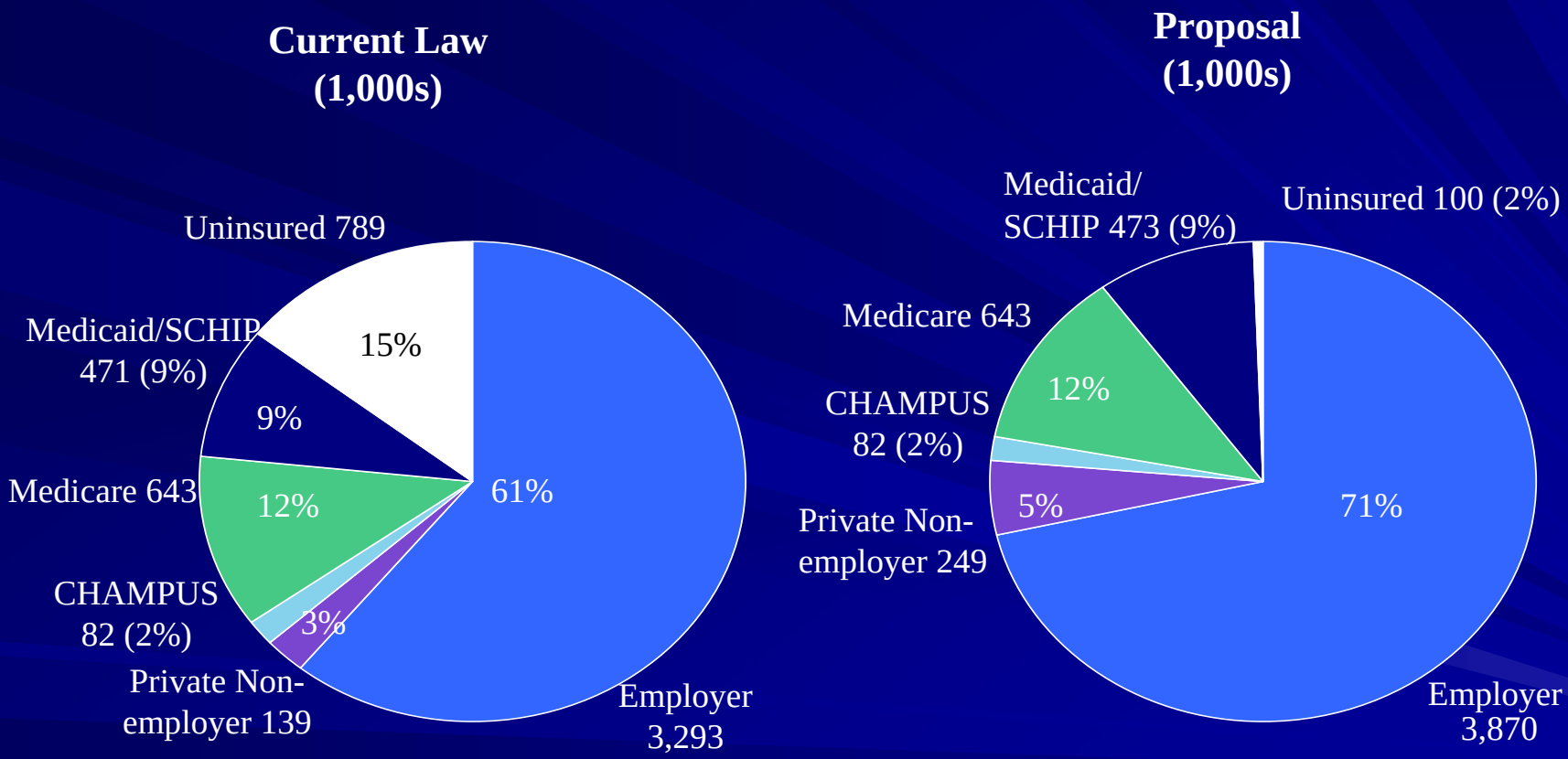
Modeling a Comprehensive Option (cont.)

- Employer Responsibility
  - Establish a Section 125 plan (cafeteria plan) for their employees
    - Deduct employee contributions to premium from wages/salary
    - Employees save both income tax and FICA tax
    - Employers save FICA taxes
  - Identify the level of contribution they would make toward premiums and/or health savings accounts
    - Part-time employees would be entitled to a proportionate share of any contributions made to full-time employees
    - Although not required to contribute toward health benefits, all employers would be encouraged to do so

- Key Results
  - Near universal coverage (98%)
  - High total cost
    - This cost can be reduced in a number of ways noted below
  - Moderate government cost per newly-insured individual
    - $3,171 before offsets from existing uncompensated care fund,
    - Similar to Kerry 2004, half that of Bush 2007
  - Substantial reduction in household expenditures
  - All businesses under 100 employees have reduced health expenditures
    - Smallest firms show greatest reduction in spending ($1262 per worker, firm <10 employees)

Modeling a Comprehensive Option (cont.)

Distribution of Marylanders by Primary Source of Coverage Under Current Law and the Comprehensive Model in 2007 (in 1,000s)



Source: Lewin Group estimates using the Health Benefits Simulation Model.

Modeling a Comprehensive Option (cont.)

- Health care spending increases $1.274 billion
- Costs and savings are distributed as follows:
  - Household spending decreases $1.748 billion
  - State and local spending increases $2.474 billion
    - State and local spending estimate should be reduced by:
      - part of uncompensated care fund reprogrammed for premium support (~$700 m)
      - Any federal matching achieved through state plan amendment or waiver
      - Savings in public health expenditures
  - Federal spending increases $548 million

Modeling a Comprehensive Option (cont.)

- Reducing the cost of the option
  - Develop a high performance plan design with narrower benefits (rather than basing the plan on the FEHBP)
  - Use a high performance provider network and/or provider incentives for high quality and low cost
  - Use less generous affordability criteria to determine the subsidy
    - more household expenditure, less government expenditure
  - Redesign the subsidy eligibility to reduce employer crowd-out – or try "maintenance of effort" provision
    - more employer expenditure, less government expenditure
  - Require employer contributions (ERISA issues)
    - more employer expenditure, less government expenditure
  - Restrict subsidy eligibility to those uninsured for >6 mos.
    - More household expenditure, less government expenditure

Less comprehensive options:
More affordable (and perhaps less challenging politically)

- A virtual exchange for the small group market
  - Provides much better information and tools to facilitate employer choice
  - Structure of the market and business arrangements are unchanged
- A separate health plan (or choice of plans) for individuals eligible for a premium subsidy
  - Could be made more affordable through careful core benefit design
  - Provides way to merge employer contribution and employee withholding with state subsidy
- An exchange for the small group market only
  - Choice of plan remains with the employer
  - Exchange products are the only products available (as in current CSHBP)
  - Individual responsibility hard to apply to SGM alone
  - With or without low income subsidies

Less comprehensive options (cont.)

- One exchange with separate individual and small group pools and products
  - Administrative advantages
  - No need to merge two different cultures and business practices
  - No need to reconcile underwriting (individual market) with modified community rating (small group market)
  - Two design options:
    - SGM retains employer choice ➔ Structure of the market and business arrangements are unchanged
    - SGM allows individual choice ➔ Exchange handles the flow of premium and subsidy dollars through contracts with TPAs

Options for Funding

- NORC examined funding options, focusing particularly on leveraging state funding

- General funds
  - Reprogramming state health expenditures for the uninsured
  - Provider tax
    - Physicians - recapture part of new physician revenue for previously uncompensated care (cf. California)
    - Hospitals – probably best approached through rate setting under all payer waiver
  - Payer tax
    - Payers already contribute through higher hospital rates under the all payer system
    - Direct tax would not be subject to hospital rate increase limits inherent in the all payer waiver
  - General taxation

Funding (cont.)

- Waivers as source of funding that leverage state funds
  - Section 1115: HIFA waivers – grants broadest flexibility in financing expansions to individuals otherwise not covered
    - Permits states to use unspent SCHIP funds, redirect DSH payments, reduce benefits and increase cost sharing to new expansion population
    - Encourages states to coordinate public-private health insurance
    - States can request federal match for state-funded programs if agree to maintain previous level of state funding
    - States have received waiver approval to impose or increase certain taxes to finances expansions
    - Must demonstrate budget neutrality over life of expansion
  - Section 1115: Research and Demonstration Projects – conduct 5 year, renewable statewide demonstrations that further the goals of Medicaid and SCHIP
    - Test innovative ideas to expand coverage
    - Request federal participation in previously state-funded programs
    - Must demonstrate budget neutrality over life of demonstration

Funding (cont.)

- State Plan Amendments - Deficit Reduction Act of 2006 grants states flexibility to reduce benefit packages and increase cost sharing primarily for expansion populations
  - States permitted to replace standard Medicaid package with a benchmark package
  - Subsequent savings can be used to finance other health insurance programs or other state budget priorities => budget neutrality.
- All-Payer System Waiver – HSCRC sets rates hospitals charge all payers
  - Rates must increases less rapidly than the national average over life of waiver
  - Reimbursement for uncompensated care included in rates
    - Covers both costs of care for the uninsured and bad debt
    - Could be applied to reduce hospital uncompensated care through premium supplementation (as is currently done with MHIP)
    - Using funds as state share of Medicaid match to increase coverage may be problematic

- Work with other states to get federal support:
  - Meaningful federal financing for state efforts to expand coverage
  - Limited exceptions to ERISA for comprehensive state reform options (set contribution requirement)

- If you put ten health policy experts in a room…